

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

9855

CERTIFICATE OF DEATH

09852
253

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i>		b. COUNTY <i>Queen Anne</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		c. LENGTH OF STAY IN 1b <i>x7</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>/</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	Fir st	Middle	Last	4. DATE OF DEATH	Month Day Year <i>Sept. 21 1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday yrs.)	IF UNDER 1 YEAR Months Days Hours Min.
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Sept. 5-1877</i>	80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
<i>FARM OWNER</i>		<i>FARM</i>	<i>Maryland</i>	<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME			
<i>JAMES WESLEY COLEMAN</i>		<i>Sarah Temperance Apsley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
(If yes, give war or dates of service)			<i>Reta Coleman</i>	<i>Chester Ind.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Hemorrhage</i>					
DUE TO (c) <i>Hypertension</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Stevensville</i>	(County) (State) <i>Ind.</i>
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Sep. 21, 1957</i> , that I last saw the deceased alive on <i>sep 19, 1957</i> , and that death occurred at <i>4 AM</i> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Stevensville Ind.</i> DATE SIGNED <i>9/23/57</i>					
ACTUAL SIGNATURE <i>W. Cleo E. Jr. Jr.</i> M.D.					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 24</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Stevensville</i>	22d. LOCATION (City, town, or county) <i>Stevensville</i>	(State) <i>Ind.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i> ADDRESS <i>Church Hill Md.</i> DATE <i>26 1957</i> REC'D BY REGISTRAR <i>E. J. A. Hooper</i> C.I.					
24b. REGISTRAR'S SIGNATURE					

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
SEP 26 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9856 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09853

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Kent</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Creamington R.F.D.</u>	c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <u>Wyoming</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Lyndon W. Cawelt</u>	First <u>Lyndon</u>	Middle <u>W.</u>	Last <u>Cawelt</u>	4. DATE OF DEATH <u>Sept 17 1957</u>	Month <u>Sept</u>	Day <u>17</u>	Year <u>1957</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	DATE OF BIRTH <u>Oct 1-1885</u>	9. AGE (In years last birthday) <u>71 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS. Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>
WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>							

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Del.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Robert Kent Cawelt</u>	14. MOTHER'S MAIDEN NAME <u>Annie D. Jones</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>222-05-5181</u>	17. INFORMANT <u>Miss Bertha Vordin</u>	Address <u>WYOMING, DEL RD #1</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto accident - Fractured skull.</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)			
	DUE TO			
	(c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year <u>2:25 p.m. 9-17-57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>state highway</u>	20f. (City or town) <u>Camden</u>	(County) <u>Del.</u>	(State) <u>Del.</u>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
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ACTUAL SIGNATURE <u>W. Henry Fisher</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>9/18-57</u>
EXAMINER'S NAME (Type) <u>Centreville Md</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/21/57</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Old Willowbriar</u>	22d. LOCATION (City, town, or county) <u>Camden Del.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Willow Millington Md.</u>	ADDRESS <u>100 N. Market St. Wilmington, Del.</u>	24a. REC'D BY REGISTRAR <u>Edgar Larey</u>	DATE <u>SEP 23 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edgar Larey</u>
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BUREAU V. S

SEP 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9857 CERTIFICATE OF DEATH

Reg. Dist. No. **119854 283**

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	c. LENGTH OF STAY IN 1b 8 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Olive Luttrell Eaton	First	Middle	Last
4. DATE OF DEATH SEPT. 11 1957	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 22, 1911
8. AGE (In years lost birthday) 45 yrs.	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Luttrell		14. MOTHER'S MAIDEN NAME Priscilla Shorey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-5034	
17. INFORMANT Gardner Eaton		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Of the Breast DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I attended the deceased from Sept. 1, 1957 to Sept. 11, 1957 that I last saw the deceased alive on Sept. 11, 1957 , and that death occurred at 11:50 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Irvin G. Hoyt M.D. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 9/11/57 PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14	
22c. NAME OF CEMETERY OR CREMATORIAL Stevensville		22d. LOCATION (City, town, or county) Stevensville Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill		24a. REC'D BY REGISTRAR DATE SEP 16 1957	
		24b. REGISTRAR'S SIGNATURE J. H. Haffey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9858

CERTIFICATE OF DEATH

09855
251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE M.D.		b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CRUMPTON		c. LENGTH OF STAY IN 1b		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRUMPTON RURAL X		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle J.	Last HAZELL	4. DATE OF DEATH SEPT. 5, 1957	Month SEPT.	Day 5	Year 1957
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 19, 1881	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE THOMAS HAZELL		14. MOTHER'S MAIDEN NAME Alice HAZELL		Address Crumpton, M.D.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 156.1		16. SOCIAL SECURITY NO. 740		17. INFORMANT GEORGE HAZELL		INTERVAL BETWEEN ONSET AND DEATH 1956	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous of Liver DUE TO Pachyria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Quinal asthrix							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 740					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 740		20f. (City or town) (County) (State) 740	
21. I certify that I attended the deceased from Sept. 4, 1957 , to Sept. 5, 1957 that I last saw the deceased alive on Sept. 4, 1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE C. H. METCALFE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/7/57		22c. NAME OF CEMETERY OR CREMATORIUM CHESTER CEM.		22d. LOCATION (City, town, or county) CHERTERTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wellington, M.		ADDRESS 1500		24a. REC'D BY REGISTRAR DATE SEP 9 1957		24b. REGISTRAR'S SIGNATURE Edgar L. Lane	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE CITY
CERTIFICATE OF DEATH

1957

BUREAU V. S.

OCT 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9859

09856

Item 1a, Film G221, 10/3/57 f.c.y.

CERTIFICATE OF DEATH

Reg. Dist. No.

257

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Centreville		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Margaret		First R.	Middle Hollingsworth	Last	4. DATE OF DEATH Sept. 15 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28-1876	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Moore		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				Miss Mildred Hollingsworth--Centreville				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cancerous of the liver								
b) Hemorrhage c) Airway - Severe								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 1 , 1957, to Sept 15 , 1957, that I last saw the deceased alive on Sept 14 , 1957, and that death occurred at 2:30 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Centreville								
DATE SIGNED Sept 15 1957								
ACTUAL SIGNATURE J.T. McPherson M.D.								
PHYSICIAN'S NAME (Type) H.E. McPherson								
22a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 17		22b. DATE THEREOF Sept. 17		22c. NAME OF CEMETERY OR CREMATORIUM Centreville		22d. LOCATION (City, town, or county) (State) Centreville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar h. Lane								
ADDRESS Church Hill, Md.								
24a. REC'D BY REGISTRAR SEP 22 1957								
24b. REGISTRAR'S SIGNATURE Philip Armstrong								

STATE DEPARTMENT OF REVENUE-SUMMONS

CERTIFICATE OF DEATH

BUREAU V.

SEP 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09857
258

Reg. Dist. No.

9860

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Queen Anne Maryland</i>		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>McGuire's Corner</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<i>John Franklin Lipscomb</i>					Sept	17	1957	

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>July 29-1947</i>	13 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>School boy</i>		Md =	U. S

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
<i>Clarence Lipscomb</i>	<i>Betty Green</i>

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	No	<i>Mrs Bettye Fisher - Chestertown</i>	<i>R.D. 1</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Auto & bicycle in Collision - boy killed</i>		
813X DUE TO (b) <i>with broken neck & broke right arm</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>9</i> p. m. <i>9-17-57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>State road</i>	20f. (City or town) <i>McGuire's - Queen An</i>	(County) <i>Queen An</i>	(State) <i>Md</i>
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>W. Henry Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>9/18-57</i>
EXAMINER'S NAME (Type) <i>Centreville Md -</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/19/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Church Hill</i>	22d. LOCATION (City, town, or county) <i>Church Hill</i>	(State) <i>Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Fisher</i>	ADDRESS <i>Church Hill</i>	24a. REC'D BY REGISTRAR <i>9/23/57</i>	24b. REGISTRAR'S SIGNATURE <i>Edgar L. Fisher</i>
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BUREAU V. S.

SEP 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

19858

9861

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sudlersville</i>	c. LENGTH OF STAY IN 1b <i>4 yrs</i>	b. COUNTY <i>Queen Anne's</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Queenstown</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <i>TILLIE MARSHALL PRATT</i>		4. DATE OF DEATH <i>Sept 14 1957</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 22-1869</i>
9. AGE (In years last birthday) 88 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Hausseger</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Charles Marshall</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Harris</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Charles O'Conney Jr., Chestertown Md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Ocute Cardiac Deterioration</i> <i>Chronic Myocarditis</i> <i>Senility</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part IV of item 18.) <i>Cerebral Hemorrhage 1950 Fracture neck femur 1957</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 14</i> , 1957, to <i>Sept 14</i> , 1957, that I last saw the deceased alive on <i>Sept 14</i> , 1957, and that death occurred at <i>5518 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Parkersville</i> DATE SIGNED <i>Sept 17 1957</i>			
ACTUAL SIGNATURE <i>A. Tillie Pratt</i>		PHYSICIAN'S NAME (Type) <i>Patricia Marshall</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>Sept 17-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chestertown</i>	22d. LOCATION (City, town, or county) <i>Chestertown Maryland</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Burton & Burton Bros Embroidery Maryland</i>	ADDRESS <i>100 Main Street Chestertown Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>9/17</i>	24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT - BUREAU OF HUMAN RIGHTS - BUREAU OF DEMOCRATIC INSTITUTIONS

CERTIFICATE OF DEATH

DATE:

NAME:

ADDRESS:

PHONE:

TELEGRAM:

TELETYPE:

TELEFAX:

TELEGRAPH:

BUREAU Y

CCP QA 1957

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

① FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or removal. **② CHIEF MEDICAL EXAMINER'S OFFICE:** Page 5 may be retained for inquiries.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
<i>Dorchester County</i>		a. STATE <i>Md.</i> b. COUNTY <i>Dorchester</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevensville</i>		c. LENGTH OF STAY IN 1b <i>X 2</i>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stevensville</i>		d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Agnes</i>			
		Last <i>Roe</i>	4. DATE OF DEATH Month <i>Sept</i> Day <i>9</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Sept 26-1908</i>	9. AGE (In years last birthday) <i>48 49 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Water</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>						
13. FATHER'S NAME <i>John C. Roe</i>		14. MOTHER'S MAIDEN NAME <i>Mary C. Hess</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Agnes Roe (Sister)</i> Address <i>Stevensville MD</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Promised to death</i> DUE TO <i>House caught fire & burned & he breathes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>to death</i> DUE TO <i>(c)</i>						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Don't know how house caught fire - but it was thought from cigarette lighting to lounge</i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 - p. m. 9-9-57 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Sisters home</i>	20f. (City or town) <i>Inr. Stevensville QA</i>	(County) <i>Md.</i>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>W. Henry Fisher</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>9/11-57</i>		
EXAMINER'S NAME (Type) <i>W. HENRY FISHER</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept. 12</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Stevensville</i>		22d. LOCATION (City, town, or county) <i>Stevensville Ind.</i>		State) <i>Ind.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clyde L. Hane Church Hill</i>		ADDRESS <i>Clyde L. Hane Church Hill</i>	24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Clyde L. Hane</i>	
			DATE			

DEPARTMENT OF HEALTH - WISCONSIN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU U. S.

SEP 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9863

CERTIFICATE OF DEATH

Reg. Dist. No.

09863

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bridgetown Rural		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle B.	Last Weaver
4. DATE OF DEATH	Month 9	Day 20	Year 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Penns.
13. FATHER'S NAME Benedict Weaver		14. MOTHER'S MAIDEN NAME Mary Kitchline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Wilson Weaver Address Henderson, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b) DUE TO c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Qanta Cerebral Hemorrhage Classic myocardi	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Paul Quinney		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 10 p. m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 19, 1957, to Sept 20, 1957, that I last saw the deceased alive on Sept 19, 1957, and that death occurred at 2111, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ridgeley, Maryland DATE SIGNED 9/22/57	
ACTUAL SIGNATURE C. W. Miller, M.D.	PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, OR CRYONICS (Specify) Burial	22b. DATE THEREOF 9/22/57	22c. NAME OF CEMETERY OR CREMATORIAL Ridgely	22d. LOCATION (City, town, or county) Ridgely, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. E. Boulaire Greensboro, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 9/22	24b. REGISTRAR'S SIGNATURE Edgar L. Lane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9864

CERTIFICATE OF DEATH

09861
Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - SUGERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.I.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE BENJAMIN WELCH</u>		First	Middle
		Last	-
4. DATE OF DEATH <u>SEPTEMBER 27 1957</u>		Month	Day
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>MARCH 4, 1893</u>		9. AGE (In years last birthday) <u>64 yrs.</u>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE FRANKLIN WELCH</u>	
14. MOTHER'S MAIDEN NAME <u>DELLA RENA BRISCOE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	
16. SOCIAL SECURITY NO. <u>220-34-9843</u>		17. INFORMANT <u>Mrs. KATHERINE B. WELCH SUGERSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hypertension</u> DUE TO <u>331X</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Cerebral arterial sclerosis</u>			
(c) <u>Coronary thrombosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>in</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>W</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>49</u> , to <u>Sept 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>57</u> , and that death occurred at <u>Sugersville</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. J. Wilkison</u>		M.D. ADDRESS (Street, city or town, state) <u>Sugersville</u> DATE SIGNED <u>Dec 10/14/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/1/57</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>SUGERSVILLE</u>		22d. LOCATION (City, town, or county) <u>SUGERSVILLE</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lawrence</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>10/1</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lawrence</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

General Hospital
General Hospital
General Hospital
General Hospital

BUREAU V. S.

OCT 4 1957

RECEIVED